Memorandum

Date AUG 7 1995

From for June Gibbs Brown
Inspector General

Subject Report on the Health Care Financing Administration's Internal Control Structure Over Medicare Accounts Receivables for the Fiscal Year Ended September 30, 1994 (A-01-94-00520)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of the U.S. Department of Health and Human Services, Office of Inspector General's report entitled, *Report on the Health Care Financing Administration's Internal Control Structure Over Medicare Accounts Receivables for the Fiscal Year Ended September 30, 1994.* As part of our audit of the Health Care Financing Administration's Fiscal Year 1994 financial statements, we are providing you the results of our internal control assessment over the processing of Medicare accounts receivable. The objective of this phase of our audit was to assess whether the internal control structure over Medicare accounts receivable was likely to prevent or detect material misstatements that could occur in reported accounts receivable balances as of September 30, 1994.

Although we generally noted improvements at Medicare contractor operations, we continue to find significant weaknesses with the recording and reporting of Medicare accounts receivable. We have provided your Chief Financial Officer with our detailed findings by contractor location under a separate memorandum. Officials in your office have concurred with our recommendations and have taken, or agreed to take, corrective action.

We would appreciate your views and the status of any further actions taken or contemplated on our recommendations within the next 60 days. Any questions or further comments on any aspect of the report are welcome. Please call me or have your staff contact Joseph E. Vengrin, Acting Assistant Inspector General for Accounting and Financial Management Audits, at (202) 619-1157.

To facilitate identification, please refer to the Common Identification Number A-01-94-00520 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REPORT ON THE HEALTH CARE FINANCING ADMINISTRATION'S INTERNAL CONTROL STRUCTURE OVER MEDICARE ACCOUNTS RECEIVABLES FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 1994

JUNE GIBBS BROWN
Inspector General

AUGUST 1995
A-01-94-00520

Memorandum

Date AUG 7 1995

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Report on the Health Care Financing Administration's Internal Control Structure Over Medicare Accounts Receivables for the Fiscal Year Ended September 30, 1994 (A-01-94-00520)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

The Chief Financial Officers Act (CFO) of 1990 requires Federal agencies to have systems of financial management, accounting, and internal controls to assure the issuance of reliable financial information. Our audit of the Health Care Financing Administration's (HCFA) Fiscal Year (FY) 1994 financial statements included an assessment as to whether the internal control structure over Medicare accounts receivable was likely to prevent or detect material misstatements that could occur in reported accounts receivable balances as of September 30, 1994. To assess the control structure we judgmentally selected for review seven fiscal intermediaries (FIs) and four carriers responsible for reporting 12.1 percent ($501.6 million) of the $4.14 billion Medicare accounts receivable balance reported at June 30, 1994 (interim financial statements).

We found that contractors have not effectively implemented all the control procedures necessary to ensure the production of reliable financial information. Important financial reporting control areas which need improvement included controls to ensure adequate documentation is retained to support reported balances, appropriate summarization and verification of accounts receivable data, reliable valuation of recorded accounts receivable amounts, and adequate safeguards and records. The following exemplifies some of the significant weaknesses we continue to find with the contractors' recording and reporting of receivable balances:

- Six contractors reviewed did not have adequate documentation or in some cases any documentation to support about $102.6 million.

- Four contractors omitted accounts receivable transactions and adjustments of about $14.4 million in their reports to HCFA.

- Three contractors reported presettlement liability cases of about $19 million, which are not accounts receivable due to the uncertainty that debt actually exists.

- All contractors reviewed either reported no allowance for uncollectible accounts or allowances that did not fairly portray the collectibility of receivables.

The processing of accounts receivables transactions does not occur within the framework of an integrated financial management system as contractors do not have accounting systems that record, classify, and summarize information for the preparation of financial statements. However, HCFA is developing an integrated financial management system within the Medicare Transaction System initiative that should enhance Medicare financial reporting. In addition, HCFA's oversight of contractor operations did not provide reasonable assurance that all control procedures were being effectively implemented.

Although we have noted continual improvements over the years, these improvements have not been sufficient to change our overall assessment of risk. As a result, we concluded that the risk was still high that HCFA and the contractors' controls would not prevent or detect, on a timely basis, material misstatements that could occur in reported accounts receivable balances at September 30, 1994. Due to the short period of time between our FYs 1993 and 1994 audit of Medicare accounts receivable balances, we acknowledge that HCFA has not had sufficient time to implement all our previous recommendations. We have worked with and will continue to assist HCFA to improve its internal control structure to provide complete, reliable, timely, and consistent financial information for efficient program management.

Accordingly, we recommend that HCFA develop an approach to review and monitor the accounts receivable internal control structure that provides management reasonable assurance that adequate controls are present. For example, the HCFA regional offices and/or the contractors could be used to assess the adequacy of the controls. To further enhance its corrective actions, we also recommend that HCFA: (i) refine the financial reporting instructions to facilitate consistent and reliable contractor reporting and (ii) provide training to contractor staff on what information is required and possible methods of obtaining and valuating the information. We also recommend that HCFA initiate the necessary steps to ensure that Medicare contractors: (i) retain proper documentation to support the reported balances and (ii) improve reporting controls to ensure that accounts receivable amounts are accurately summarized and valued at appropriate amounts.

In response to our draft audit report, HCFA concurred with our assessment that improvements are still necessary in HCFA's recording and reporting of Medicare accounts receivable. To improve the quality of financial data it receives from Medicare contractors, HCFA has developed a protocol for Medicare contractors to use to self-assess their internal control structure. In addition, HCFA is in the process of conducting CFO seminars to educate Medicare contractors regarding the preparation of financial reports, and finalizing revised financial reporting instructions which should clarify certain ambiguities in the current directives. The HCFA is also in the process of developing the Medicare Transaction System, a fully integrated financial management system, to facilitate uniform contractor financial reporting.

INTRODUCTION

Background

The HCFA, within its overall administration of the Medicare program, has delegated to contractors the responsibilities for processing claims, accounting for and collecting overpayments, and executing other day-to-day operational responsibilities of the Medicare program. As such, we designed our review to obtain an understanding of the internal control structure at HCFA and the Medicare contractors and to report any potential weaknesses that could adversely affect management's ability to execute its responsibilities.

The CFO Act requires Federal agencies to improve its systems of financial management, accounting, and internal controls to assure the issuance of reliable financial information. The Office of Management and Budget (OMB) Circular A-123, *Internal Control Systems*, sets forth the policies and procedures to be followed in establishing, maintaining, evaluating, improving, and reporting on internal controls. One internal control objective is to ensure that transactions applicable to agency operations are recorded and accounted for properly so that accounts and reliable financial and statistical reports may be prepared and accountability of the assets may be maintained.

The HCFA implemented a procedure for Medicare contractors to report financial data on the *Contractor Financial Reports*, HCFA-750A/B and *Status of Accounts Receivable*, HCFA-751 A/B (HCFA 750/751). The accounts receivable data reported on these reports are used by HCFA to prepare its financial statements.

Scope

The objective of our review was to assess the control risk relative to the probability that HCFA's and the Medicare contractors' controls were likely to prevent or detect material misstatements that could occur in reported accounts receivable balances as of September 30, 1994. To achieve our objectives, we reviewed the internal controls over accounts receivable at HCFA and 11 judgmentally selected contractors that included 7 FIs and 4 carriers nationwide. These selected contractors were responsible for reporting 12.1 percent ($501.6 million) of the $4.14 billion Medicare accounts receivable balance reported at June 30, 1994 (interim financial statements). The contractors included Blue Cross of Connecticut (FI), Blue Cross of Massachusetts (FI), the Travelers (carrier) at two locations--Connecticut and Virginia, Blue Cross of Maryland (FI), Blue Cross and Blue Shield of Alabama (FI and carrier), Health Care Service Corporation of Illinois (FI and carrier), Blue Cross and Blue Shield of Texas (FI and carrier), and Blue Cross of California (FI). Our review was performed from August through October 1994 and was conducted in accordance with generally accepted government auditing standards.

We designed our review to obtain an understanding of HCFA's internal control structure, including the contractors, and to identify potential weaknesses that could adversely affect management's ability to report reliable financial information. Our review involved (i) obtaining an understanding of the different systems used by HCFA and the contractors to identify, record and report accounts receivable information; (ii) identifying financial reporting control procedures and evaluating the effectiveness of such controls; (iii) reconciling and limited testing of balances reported at June 30, 1994 on the HCFA 750/751; and (iv) assessing control risk. Our review at Blue Cross and Blue Shield of Alabama was limited to the controls in place for the recording and reporting of Medicare secondary payer (MSP)[1] overpayment amounts. In addition, our review of MSP controls in place at Blue Cross of Massachusetts concentrated on whether the contractor implemented corrective actions regarding previously identified control problems.

In order to facilitate our assessment of control risk, we developed a materiality threshold. Materiality represents the magnitude of an omission or misstatement of an item in a financial report that, in light of surrounding circumstances, makes it probable that the judgement of a reasonable person relying on the information would have been changed or influenced by the inclusion or correction of the item. Initially, auditors establish materiality thresholds at the aggregate financial statement level. In planning the extent of audit work needed at the contractor level, we allocated a portion of the materiality threshold to each contractor.

The aggregate materiality threshold we established was $206.6 million which was calculated on the basis of the total Medicare accounts receivable balances of $4.14 billion reported at June 30, 1994. The materiality threshold allocated to the 11 contractors visited totaled $31.6 million which was based upon their reported accounts receivable balances of $501.6 million at June 30, 1994. The specific materiality threshold for the contractors visited ranged from $750,000 to $8.7 million. We met with HCFA officials before we began our audit work to review our test approach and materiality thresholds.

If we identified errors and omissions at the contractors which exceeded our materiality threshold, we concluded that the risk was high that the controls would not prevent or detect material misstatements in the amounts reported at September 30, 1994. At some contractors, we identified errors and omissions which exceeded our materiality levels before we had completed all of our audit tests. At those sites we concluded that the control risk was high and elected to discontinue further audit work. Consequently, not all contractors' controls were reviewed at all sites. As such, our list of control weaknesses contained in his report may not be all inclusive.

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[1]Medicare secondary payer refers to situations where Medicare payment is secondary to certain types of private insurance coverage.

The draft report was issued to HCFA on March 7, 1995. The HCFA's written comments, dated May 15, 1995, are summarized on page 11 and appended in their entirety at the end of this report (see APPENDIX).

FINDINGS AND RECOMMENDATIONS

Although we have noted continual improvements in the Medicare accounts receivable internal control structure over the years, these improvements have not been sufficient to change our overall assessment of risk. Contractors have not yet effectively implemented all the control procedures necessary to ensure the production of reliable financial information. At 10 of the 11 contractors visited, we found control weaknesses that resulted in material recording and reporting errors and omissions. As explained in the *Scope* section, errors and omissions were considered material to a specific contractor if they exceeded a specific dollar threshold.

In addition, HCFA's oversight of contractor operations did not provide reasonable assurance that all control procedures were being effectively implemented. We realize that HCFA is developing an integrated financial management system within the Medicare Transaction System initiative that should enhance the Medicare financial reporting. However, the processing of accounts receivables transactions still does not occur within the framework of an integrated financial management system.

Financial Reporting Controls Should Be Strengthened To Implement Contractor Reporting

Our review showed that contractors have not yet effectively implemented all the control procedures necessary to ensure that the HCFA 750/751 produced reliable financial information. Important financial reporting control areas which need improvement included controls that ensure adequate documentation is retained to support reported balances, appropriate summarization and verification of accounts receivable data, reliable valuation of recorded accounts receivable amounts, and adequate safeguards and records. At 10 of the 11 contractors visited we found control weaknesses that resulted in material recording and reporting errors and omissions.

We reviewed controls to determine whether the recorded receivables were supported by appropriate documentation. Six of the 11 contractors reviewed did not have adequate documentation or in some cases any documentation to support about $102.6 million reported on the HCFA 750/751. As a result, the reported amounts could not be substantiated.

We reviewed controls to determine whether transactions and adjustments were accurately summarized. Contractors still do not reconcile detail accounts receivable amounts with the summary amounts reported to HCFA. As a result, errors and omissions continue to occur. For example, we found that four contractors omitted accounts receivable transactions and adjustments of about $14.4 million in their reports to HCFA. We also found that three contractors reported presettlement liability cases of about $19 million, which are not accounts receivable due to the uncertainty that debt actually exists. In addition to the significant problems above, we noted that account balances were

recorded twice, reported balances were both overstated and understated in relation to the supporting documentation, transpositional errors overstated and understated reported balances, and beginning accounts receivable balances did not reconcile with contractors' supporting accounting records.

We reviewed control procedures to determine whether independent verification checks were conducted to provide reasonable assurance as to the validity, accuracy, and completeness of processed data. We found areas where the contractors needed to strengthen its controls to ensure that independent checks were performed. For example, we found that management or independent personnel did not review reported amounts and internal audits of the accounts receivable function were not performed during FY 1994.

We reviewed controls to determine whether receivables were valued at appropriate amounts. For instance, an allowance account should be established when collection of the receivable is in doubt and the amount of loss can be reasonably estimated. However, we found weaknesses in controls which did not detect a zero balance for the allowance for uncollectible accounts or allowances that did not fairly portray the collectibility of receivables for all 11 contractors reviewed. We also found other weaknesses in controls which did not detect errors in estimating account balances and errors in estimating the allocation of accounts receivable balances among the Health Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds.

We also reviewed control procedures to determine whether there were adequate safeguards and records, and duties were properly segregated. These controls typically are designed to protect assets against theft, loss, misuse, or unauthorized alteration and reduce the opportunities for someone to both perpetrate and conceal errors or irregularities. Although we previously noted similar weaknesses in our report on HCFA's internal control structure for the year ended September 30, 1993,[2] we found that a contractor needed to strengthen its controls to ensure adequate safeguards and segregation of duties. For example, we found (i) checks were not recorded to a cash receipt log upon receipt, as the first recording of the checks was made to the bank deposit slip, and (ii) one individual was responsible for receiving and endorsing checks, preparing and recording deposits, and performing bank reconciliations.

Financial Management System

The OMB Circular A-127, *Financial Management Systems*, which implements the CFO Act and the Federal Managers' Financial Integrity Act of 1982, requires agencies to

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[2]Final Report entitled, "Report on the Health Care Financing Administration's Internal Control Structure and Compliance With Laws and Regulations for the Fiscal Year Ended September 30, 1993," dated September 1994.

establish and maintain a single, integrated financial management system. The HCFA is developing an integrated financial management system as part of the Medicare Transaction System initiative that should enhance its financial reporting.

The HCFA and Medicare contractors maintained and utilized various systems to process and accumulate accounts receivable data that does not occur within the framework of an integrated financial management system. The systems were primarily designed to track overpayments from different contractor activities, and were not part of a fully integrated financial management system containing attributes such as full accrual accounting, proper cut-off procedures, and adequate source documentation. In addition, contractors do not have accounting systems that record, classify, and summarize information for the preparation of financial statements.

HCFA's Oversight of Contractor Operations

The HCFA's oversight of contractor operations did not provide reasonable assurance that financial reporting control procedures were being effectively implemented. The HCFA 750/751 instructions to the contractors did not adequately communicate financial reporting control requirements, nor did HCFA's oversight procedures adequately evaluate financial reporting controls at contractor operations.

We recognize that the HCFA 750/751 is a relatively new and constantly evolving process designed to provide a method of reporting financial activities by the Medicare contractors according to the CFO Act. The HCFA has modified its HCFA 750/751 instructions from period to period. We believe that some of our observations at contractors demonstrate that the current reporting requirements still need refinements to ensure consistent and reliable information. For instance, the HCFA instructions state that:

- The FIs should record peer review organization (PRO) post-payment adjustments to the "Accounts Receivable, PRO" account. The instructions are not specific as to whether FIs should net any PRO accounts payable adjustments against the receivable account.

- Contractor certification is required. However, it is not specific as to the official that should certify the reports.

- Contractors should record periodic interim payments (PIP) in excess of PIP bills and overpayments. The instructions are not specific as to whether the contractors should net PIP accounts payable adjustments against the PIP accounts receivable account.

- Contractors should report accounts receivable to HI and SMI activities. Contractor reporting systems are not always able to categorize and report actual overpayments to the HI or SMI trust funds, thus contractors must develop estimates for

allocating receivables to the appropriate funds. In this respect, we believe HCFA should provide more specific guidance related to the proper methodology for allocating receivables to the respective Medicare trust funds when estimates become necessary.

- Contractors should use 5 years of historical loss data, when available, for calculating the "Allowance for Uncollectible Accounts." This 5-year data may not be available to some contractors. The HCFA should emphasize in its allowance instructions that, in the absence of 5-year historical loss experience, contractors should maintain and use the most representative historical collection data available. This data should be particularly instrumental for calculating the MSP allowance accounts to properly reflect the significant portion of uncollectible MSP.

Additionally, there was no assessment by HCFA to determine whether FY 1994 transactions were properly authorized and summarized, duties were adequately segregated, or independent checks were being performed.

Conclusions And Recommendations

We found that the internal control structure at the contractors reviewed needs to be strengthened to ensure the recording and reporting of reliable financial data for financial statement purposes. At 10 of the 11 contractors visited, we found control weaknesses that resulted in recording and reporting errors and omissions that exceeded our materiality threshold. As a result, we concluded that the risk is still high that the contractors' controls will not prevent or detect, on a timely basis, material misstatements that could occur in reported accounts receivable balances at September 30, 1994.

In order to correct the conditions addressed in this report, we recommend that HCFA:

1. Develop an approach to review and monitor the accounts receivable internal control structure that provides management reasonable assurance that adequate controls are present. For example, the HCFA regional offices and/or the contractors could be used to assess the adequacy of the controls.

2. Establish an integrated financial management system to promote consistency and reliability in recording and reporting accounts receivable information. Ensure that the current systems provide consistent and reliable information required on the HCFA 750/751 until an integrated financial management system is established under the Medicare Transaction System initiative.

3. Refine the financial reporting instructions to facilitate consistent and reliable contractor reporting. For instance, the instructions should be more specific in regards to:

   - the appropriate official, such as the CFO, that should certify the financial reports;
   - the appropriate contractor methodology for allocating receivables to the respective Medicare trust funds;
   - whether the contractor should net PRO and PIP accounts payable against PRO and PIP accounts receivable; and
   - the contractors' use of the most representative historical collection data available, in the absence of 5-year historical loss experience, to estimate their allowances for uncollectible accounts.

We also recommend that HCFA initiate the necessary steps to ensure that Medicare contractors:

4. Retain proper documentation to support the reported balances.

5. Receive training on what information is required and possible methods of obtaining and valuing the information.

6. Improve reporting controls to ensure that accounts receivable amounts are accurately summarized and valued at appropriate amounts. In addition, require that contractors develop procedures to implement the HCFA 750/751 instructions.

7. Develop control procedures to provide independent checks by management on the validity, accuracy, and completeness of the amounts reported to HCFA, including a reconciliation with the contractors' supporting documentation.

8. Strengthen existing internal controls related to the segregation of duties, especially in the cash/checks receipts areas.

HCFA Comments

In response to our draft report, HCFA concurred with all eight recommendations. In this respect, HCFA indicated that it has implemented or is in the process of implementing the following improvements:

- Develop a protocol for Medicare contractors to perform self-assessments of their internal control structure.

- Conduct CFO seminars to educate Medicare contractors regarding the preparation of financial reports.

- Ensure that the prospective Medicare Transaction System is designed with a detailed integrated financial management system that will provide accounting data directly to HCFA's core accounting system.

- Revise its financial reporting instructions to facilitate consistent and reliable contractor reporting.

- Ensure its Medicare contractors retain the proper source documentation to support the reported accounts receivable balances.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date MAY 15 1995

From Bruce C. Vladeck
Administrator

Subject Office of Inspector General (OIG) Draft Report: "Report on the Health Care Financing Administration's (HCFA) Internal Control Structure Over Medicare Accounts Receivables for the Fiscal Year (FY) Ended September 30, 1994" A-01-94-00520

To June Gibbs Brown
Inspector General

We reviewed the above-referenced report in which OIG concluded that while HCFA has made improvements in controls over Medicare accounts receivables for FY 1994, improvement in recording and reporting processes for receivables is still needed.

We concur with the recommendations in the report, and we have started conducting training to ensure timely corrective action.

Our detailed comments on the report findings and recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this draft report. Please contact us if you would like to discuss our comments and response.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG) Draft Report:
Report on the Health Care Financing Administration's
Internal Control Structure Over Medicare Accounts Receivables
for the Fiscal Year (FY) Ended September 30, 1994
A-01-94-00520

OIG Recommendation 1

Develop an approach to review and monitor the accounts receivable internal control structure that provides management reasonable assurance that adequate controls are present. For example, the HCFA regional offices (RO) and/or the contractors could be used to assess the adequacy of the controls.

HCFA Response

We concur. HCFA and OIG worked with a contractor in FY 1995 to develop a protocol for Medicare contractors to use to self-assess their internal control structure. Additionally, HCFA issued a memorandum on November 28, 1994, to all Medicare contractors which requires the Medicare contractors to certify that they are in compliance with the Federal Managers Financial Integrity Act (FMFIA) and Chief Financial Officer (CFO) Act. The certification is required within 30 days of the date of the memorandum. The memorandum also requires a second certification by September 1, 1995, along with a summary of the actions taken to ensure compliance with the FMFIA requirements.

OIG Recommendation 2

Establish an integrated financial management system to promote consistency and reliability in recording and reporting accounts receivable information. Ensure that the current systems provide consistent and reliable information required on the HCFA-750/751 until an integrated financial management system is established under the Medicare Transaction System initiative.

HCFA Response

We concur. To promote consistency and reliability in reported data, HCFA is conducting seminars to train Medicare contractors in the preparation of reports and is discussing changes in the draft manual instructions that will require Medicare contractors to comply with the CFO Act and the FMFIA. HCFA staff are also reviewing and discussing reports individually with each contractor, and making themselves available to answer questions.

Additionally, Financial Accounting Control System (FACS) for all Medicare accounting is linked to the Medicare contractors' financial systems by the HCFA-750A/B, Financial Reports, and the HCFA-751A/B, Status of Accounts Receivable, which are captured electronically by HCFA's Contractor Administrative-Budget and Financial Management (CAFM) system. FACS and the Medicare contractors financial systems are required to comply with the FMFIA and the CFO Act. However, we recognize that improvements are needed, and the Medicare Transaction System is being designed with a detailed, integrated financial management system that will provide accounting data directly to HCFA's core accounting system.

OIG Recommendation 3

Refine the financial reporting instructions to facilitate consistent and reliable contractor reporting.

HCFA General Comments

We concur. We recognize that more improvements are necessary to strengthen financial reporting processes. OIG and HCFA staffs have been working to resolve our mutual concerns. The instructions developed in FY 1993 were revised and sent to the Medicare contractors as draft manual instructions in FY 1994 with a request for comments. Those comments and other HCFA concerns are being addressed in the CFO seminars referenced in item 2 above. The revised draft instructions should be finalized by the end of FY 1995.

For instance, the instructions should be more specific in regards to:

- o the appropriate official, such as the CFO, who should certify the financial reports;

  HCFA Response

  The revised manual instructions will require an authorized official to certify the financial reports. That official could be the CFO or another person within the contractor's organization depending on the Medicare contractor's business organization and reporting hierarchy.

- o the appropriate contractor methodology for allocating receivables to the respective Medicare trust funds;

HCFA Response

When receivables are booked, the Medicare contractors record whether it is health insurance (HI) (primarily hospital inpatient overpayments) or supplemental medical insurance (SMI) (primarily hospital outpatient overpayments).

Our revised manual instructions on accounts receivable/accounts payable protocol for estimating claims prorate estimated receivables between HI and SMI trust funds in accordance with bill types.

- whether the contractor should net peer review organizations (PRO) and periodic interim payment (PIP) accounts payable against PRO and PIP accounts receivable;

HCFA Response

Our revised manual includes the Medicare contractor account definitions for overpayments at section 1310.01.03, PRO Review, which will require the Medicare contractor to report receivables due from those providers that the PRO adjusted. For payables, section 2110.01.03.04, PRO Review, requires the Medicare contractor to report payables due to those providers that the PRO adjusted.

The revised manual Medicare contractor account definitions for overpayments at section 1310.01.01.01, Provider, require the Medicare contractor to report receivables due from those providers that have biweekly PIP payments in excess of PIP bills. For payables, section 2110.01.02.01, Provider, requires the Medicare contractor to report payables due to those providers that have PIP bills in excess of biweekly PIP payments.

Compliance with these instructions precludes Medicare contractors from reporting PRO or PIP receivables and payables net.

- the contractors' use of the most representative historical collection data available, in the absence of 5-year historical loss experience, to estimate their allowances for uncollectible accounts.

HCFA Response

HCFA does not specify a formula to determine the Medicare contractors' allowances for uncollectible accounts using a 5-year historical loss experience or any representative historical collection data that are available. However, Medicare contractors are required to use this information if it is relevant.

Medicare contractors are required, in accordance with U.S Treasury reporting instructions for the SF-220 Schedule 9, Report on Accounts and Loans Receivable Due From the Public, to analyze the accounts to estimate the probability of failure to collect based on risk factors.

OIG Recommendation 4

Retain proper documentation to support the reported balances.

HCFA Response

We concur. The HCFA-750/751 instructions require Medicare contractors to keep documentation and list the documents. In addition, HCFA ROs review contractors' records to ensure source documentation is available for the numbers reported.

OIG Recommendation 5

Receive training on what information is required and possible methods of obtaining and valuing the information.

HCFA Response

We concur. See response to OIG recommendation 2 above.

OIG Recommendation 6

Improve reporting controls to ensure that accounts receivable amounts are accurately summarized and valued at appropriate amounts. In addition, require that contractors develop procedures to implement the HCFA-750/751 instructions.

HCFA Response

We concur. See responses to OIG recommendations 1, 2, and 3 above. In addition, the CFO seminars discussed in recommendation 2 stress that the Medicare contractors must have written procedures for use by OIG on how they develop data reported on the HCFA 750/751.

OIG Recommendation 7

Develop control procedures to provide independent checks by management on the validity, accuracy, and completeness of the amounts reported to HCFA, including a reconciliation with the contractors' supporting documentation.

HCFA Response

We concur. See responses to OIG recommendations 1 and 4 above.

OIG Recommendation 8

Strengthen existing internal controls related to the segregation of duties, especially in the cash/checks receipts areas.

HCFA Response

We concur. See response to OIG recommendation 1 above.